ST JOHN OF GOD
Raphael Services

REFERRAL FORM

GP Name ....

Address ....

Phone ....

Email .... Date ....

Signature ....

Use BLOCK LETTERS

Instructions: See Inclusion / Exclusion Criteria over page. Where client is eligible for referral, Mental Health Care Plan is required.

Perinatal Status: Antenatal ☐ Post Natal ☐ Pre-conception ☐

Client Name: ______________________ Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Age: ☐☐

Address: ______________________ Email: ______________________

Phone: Home ☐☐ ☐☐☐☐ ☐☐☐☐ Mobile ☐☐☐☐ ☐☐☐ ☐☐☐

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Line Number ☐ Expiry: ☐☐/☐☐☐☐

HCC / Pension Card: Yes ☐ No ☐ Maternity Hospital: ______________________

Due / Birth Date: ______________________ Infant name: ______________________

Proficiency in Spoken English: Very Well ☐ Well ☐ Not Well ☐ Not at All ☐

REASON FOR REFERRAL: Depression ☐ Anxiety ☐ Bipolar ☐ Attachment concerns ☐
Adjustment Disorder ☐ Grief / Loss (e.g. Stillbirth / Neonatal death) ☐ Birth trauma ☐
Other ______________________

Symptoms of concern (Tick if present)

Symptom	**Present**	**Symptom**	**Present**
Insomnia / hypersomnia		Reduced ability to concentrate	
Decreased need for sleep		Feelings of worthlessness	
Recent changes to appetite / weight		Feelings of hopelessness	
Agitated / irritable		Feelings of guilt	
Restless, feeling on edge		Tearful	
Racing thoughts		Excessive worry	
Distressing recollections of trauma		Obsessive thoughts	
Hypervigilance		Compulsive actions that cause distress	
Inflated self - esteem		Feeling numb or detached	
Thinking / movement slowed		Muscle tension	
Loss of interest or pleasure		Excessive frustration with child / infant	
Fatigue or loss of energy		Concerns with child / infant bond	

Other symptoms of concern: ______________________

Past medical & obstetric history: ______________________

Current medications: ______________________

Risks to self, infant or others (*Please see Risk Assessment Decision Tree over page)*

Nil identified ☐ Low risk ☐ Medium risk ☐ High risk ☐

Psychosocial risk indicators (Tick if present)

Psychosocial risk indicators	**Present**	**Psychosocial risk indicators**	**Present**
Past history of perinatal mental illness		Family violence	
Past history of mental illness		History of trauma	
Family history of perinatal mental illness		Tobacco use	
Family history of mental illness		Alcohol use	
IVF or other reproductive assistance		Other drug use	
Lack of support from partner		Child protection involvement	
Other supports available		Decline in psychosocial functioning: eg. work, parenting ability, home duties, ADLs, relationships	

NO WRITING IN MARGINS

SGCZWLFT5014 10/18

REFERRAL FORM

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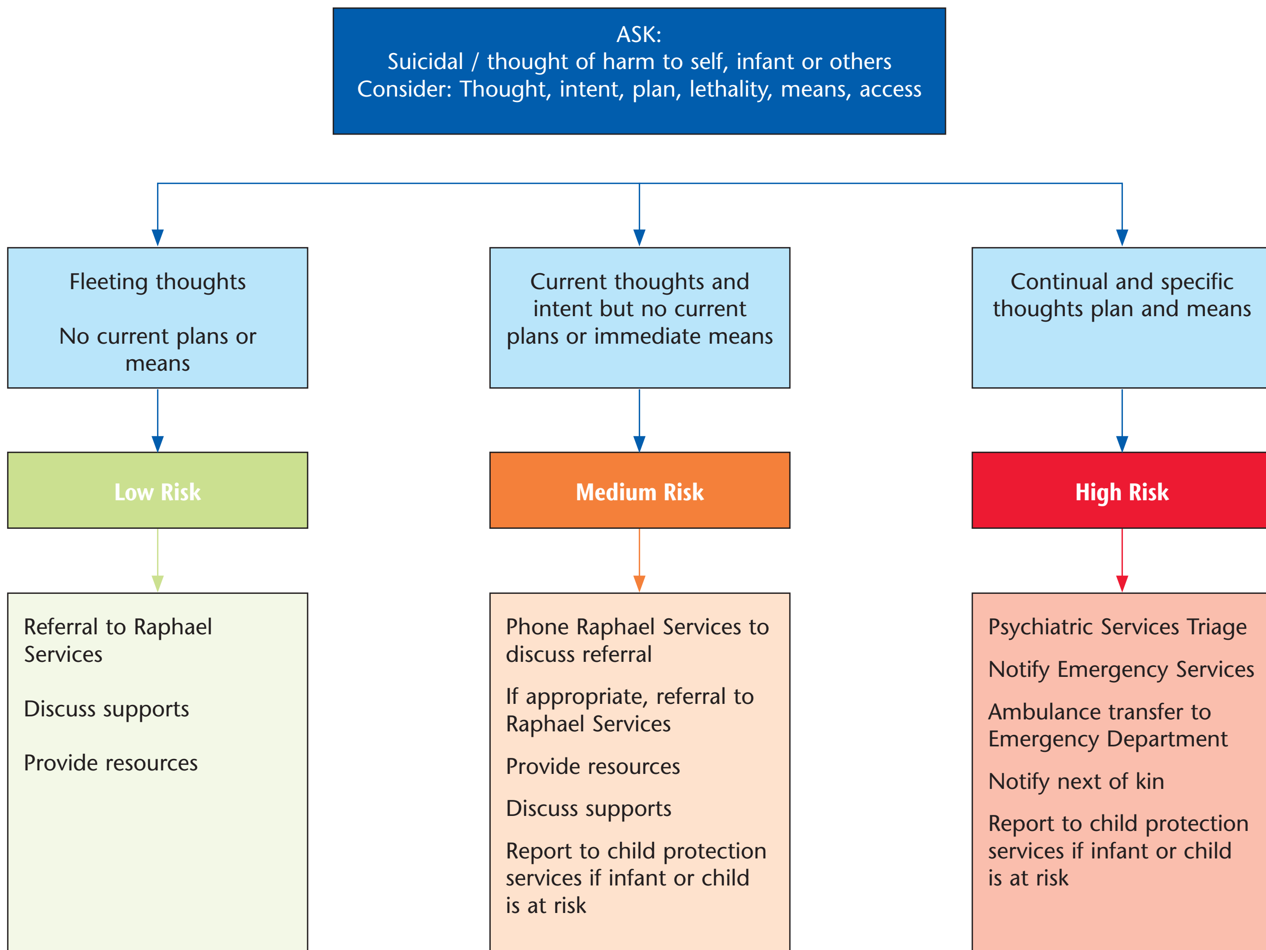
Raphael Services Inclusion Criteria

1. Depression, anxiety or related disorders from pre-conception up until the index child's fourth birthday.
2. Grief or loss associated with pregnancy or associated trauma.
3. Problems in the parent-child relationship related to parents perinatal mental health concern.

Raphael Services Exclusion Criteria

1. Active psychotic symptoms or a crisis presentation; active suicidal / homicidal intent; significant child protection issues; past or present history of violence or aggression; current alcohol or drug disorders unless actively engaged in treatment

Risk Assessment Decision Tree



NO WRITING IN MARGINS

Raphael Services Intake and Assessment Process – please discuss with your patient at the time of referral: